STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155178	A. BUILDING _____ B. WING _____	02/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-FOUNTAINVIEW	609 W TANGLEWOOD LANE MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for a Recertification and State Licensure Survey. Survey dates: February 20, 21, 22, 23, and 24, 2011 Facility Number: 000094 Provider Number: 155178 AIM Number: 100290310 Survey Team: Becky Luft RN, TC Toni Krakowski, RN Vicki Manuwal, RN Census Bed Type: SNF/NF: 111 Total: 111 Census Payor Type: Medicare: 17 Medicaid: 69 Other: 25 Total: 111 Sample: 23 Golden Living Center-Fountainview was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Recertification and State Licensure Survey. Quality review 2/25/11 by Suzanne Williams, RN	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.